COMMON GROUND
HEALTHCARE COOPERATIVE

May 21, 2019

The Honorable Lloyd Doggett, Chairman
House Ways and Means Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

Submitted via email to WMDem.Submission@mail.house.gov.

Dear Chairman Doggett,

On behalf of more than 60,000 members of Common Ground Healthcare Cooperative, we write to express our strong support for legislation that addresses the practice of balance billing, also known as "surprise bills" for patients, while striking an ***appropriate and transparent*** balance between provider charges and insurance company payments.

Common Ground Healthcare Cooperative (CGHC) is a Wisconsin-based insurance cooperative that was created to help individuals gain access to affordable, quality coverage. What makes us different is that we are focused on the needs of consumers, not on making a profit. We are also recognized as a "Consumer Operated and Oriented Plan" (CO-OP) under federal statutes. As such, we started offering insurance in 2014, and today we are now the largest individual market carrier serving the state of Wisconsin. Because we are non-profit, service to our members is what drives our cooperative, and their best interests is what guides our decision-making.

Balance billing is a significant problem for our members. Real-life examples of balance billing that our members have experienced are as follows:

- A member goes to their doctor and the doctor recommends the patient to be admitted to the in-network hospital "for observation." The company that performs the observation on behalf of the hospital is out-of-network and the member receives a balance bill. (This can also occur with anesthesiologists and other specialists that may work within the hospital walls. Members won't know care is being provided by an out-of-network provider in these situations, unless they happen to be well enough and think to ask. And even if they ask, they can do little to impact the outcome.)
- A member presents in the emergency room of an in-network hospital and needs an emergency tracheotomy. The on-call surgeon that day is an out-of-network provider. The member receives a balance bill from the out-of-network, on-call surgeon, for amounts over and above what we will pay for services.

- A member is sent to the only level-one trauma center operating in our area, due to medical necessity. The member receives a balance bill from the ER trauma center for the amounts over and above what we pay for services. He or she may also receive a balance bill from the medical transport company.
- A member is traveling to another state and experiences a near-fatal emergency. He is sent back home via an air-ambulance to live out his remaining days. The member is now facing a possible $470,000 in balance billed air ambulance charges.

When our members experience an emergency and are forced to seek care from a provider that is not part of our network, we reimburse the non-network providers two and a half times what Medicare would reimburse. Still, our members receive balance bills from the providers. We also reach out to non-network providers to negotiate a single case agreement so the member will not be balance billed. Sadly, we are only successful only half of the time.

You may ask why we don't bring medical transport companies, anesthesiologists and the only level-one trauma center in our area in our network? It is not possible. Anesthesiologists, similar specialists, medical transportation companies and monopoly providers often refuse to contract with insurers. They can maximize profits by not being in network.

It has become clear to us that for some (not all) providers, only a blank check will do. This is not a reasonable expectation for our members who are generally making between 100% and 400% of the federal poverty level or who are self-employed and paying 100% of their premiums on their own. Our offer of a reasonable payment and our willingness to come to the table to negotiate amounts to protect our members are too often rebuffed by providers. For that reason, we believe federal legislation is necessary to address this issue.

There are five provisions we believe must be included to fully protect consumers that we detail below.

1. A Percentage of Medicare is the Appropriate Benchmark for Out-of-Network Emergency Care

Lawmakers from both parties seem to agree that something should be done to end surprise billing for out-of-network emergency care that is now mandated for coverage. A recent study by the Health Care Cost Institutes shows that the mandate has increased charges for emergency care.

CGHC has reviewed the "No Surprises Act" discussion draft released by the House Energy and Commerce Committee. We are pleased to see the bill does not employ an arbitration method for settlement between providers and payers which we fear will prolong the process of settling a patient's charges and add administrative costs. And while the proposed methodology is preferable to an arbitration method, it is not the most appropriate method available.

We support a Medicare based reimbursement rate for several reasons:

1. **Transparency.** A Medicare-based reference percentage (with a Medicaid fallback if necessary) is fully transparent to providers, patients, insurers and lawmakers. For those of us that believe that we must help patients behave as consumers by enabling price transparency, this is by far the most transparent solution.
2. **Equity.** Medicare establishes its reimbursement levels in a way that must be fair to all hospitals, with several factors considered that are hotly debated, and rates are adjusted for regional and severity differences. Conversely, a median or usual and customary benchmark would consider several payers' negotiated payments amounts. There could be enormous price differentials in these payment amounts based on nothing more than market power and the process of negotiation. These prices are secret. As a result, the swings in amounts can vary significantly, distorting payment medians or averages.
3. **Cost.** Insurers must pay entities such as Fair Health to license their data on usual and customary. This adds unnecessary cost that is ultimately passed to consumers.
4. **Accountability.** Using a non-Medicare entity to establish usual and customary sows seeds of distrust as to whether the data is appropriately measured. This is an area subject to intense scrutiny and previous court action. Using Medicare as a reference eliminates ensures that payment disputes can be resolved outside of the court system.

2. In-Network Facilities Must Notify Patients About Out-of-Network Providers

Too many of our members discover after their care or treatment is completed that an out-of-network provider has been involved. If a facility allows out-of-network providers to practice within its walls, they should be required to inform patients that this is happening and provide an estimate of the anticipated charges. This should happen at the time the patient schedules the treatment so he or she can make an informed choice about their care.

We applaud the No Surprises Act for also including this provision and a provision that requires an informed consent document be signed before balance billing can occur. This is the right step for Congress to take to protect health care consumers.

3. Out-of-Network Providers Practicing in In-Network Facilities Must Accept In-Network Payments

In the case of an insured member that goes to an in-network hospital for care, we believe any provider caring for the hospital's patients must accept the participating hospital's contracted rate for services. Providers practicing within a hospital's four walls should be prohibited from balance billing a patient for amounts above and beyond the hospital's contracted rate. It is not right that consumers who believe they were seeking in-network care should be saddled with surprise bills, and it is not right that insurers that contract with these hospitals in good faith should have to pay more because the hospital contracted for out-of-network services.

While the No Surprises Act proposes a benchmark payment which we applaud, we are concerned that if the benchmark is over and above contracted rates then the consumer member is paying more in deductibles and coinsurance.

4. The Legislation Must Address Ambulance and Air Ambulance Charges

In our area, ground ambulance providers do not contract with insurers, and members are sometimes balance billed for ambulance charges that are over and above what we pay for services. It does not appear that the No Surprises Act addresses this gap for consumers.

When ambulance providers are providing emergency services, they should be subject to the same method of reimbursement that other emergency providers will be subject to should the No Surprises Act pass. This includes air ambulance providers, who in our experience are putting families in financial crisis. It is unconscionable that our member, who lost her husband shortly after the ambulance brought him home, is now being threatened with a $470,000 balance bill against his estate. We urge Congress to determine out a reasonable payment for these services and include air ambulance and other ambulance providers in the legislation that we hope will be signed into law.

5. The Legislation Should Give Payers a Choice Between State and Federal Payment Options

We appreciate that the legislation recognizes states' efforts to address this important issue. But we are also aware that some state efforts may not go as far as the federal government in protecting consumers, due to heavy lobby and special interest influence.

Congress certainly recognizes by now the attention and money that special interest lobbying organizations are paying in relation to this issue. We would not want to see Congress stand up to special interests to do what's right for consumers only to see separate battles play out state by state that could weaken the federal impact. For that reason, payers should be able to opt for a federal versus state solution so we can go as far as legally possible to protect consumers.

Conclusion

On behalf of our members, we strongly urge you to support federal legislation to protect consumers from surprise bills. We believe that a percentage of Medicare is the appropriate reference basis for pricing, and that additional consumer protections must be included in the legislation. If you have any questions, please do not hesitate to contact Melissa Duffy, Government Affairs, at (608) 334-0624. Thank you for your time and consideration.

Sincerely,

Cathy Mahaffey, CEO
Common Ground Healthcare Cooperative, WI